IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0058 · (208) 327-7000
Express Mail: 1755 Westgate Drive, #140 · Boise, ID 83704

APPLICATION - POLYSOMNOGRAPHY RELATED RESPIRATORY CARE PERMIT

FOR USE OF THE BOARD						
1. Prof. Education	2. Training	3.BRPT	4. Recommendation	Received	PSG Trainee #	PSG Permit #
5. Recommendation	6. Verification	7. Supervisor	CPR	Fees	Date	Date

Before completing, please see instructions.

I hereby apply to provide polysomnography related respiratory care as a:

- ☐ PSG Technologist
- ☐ PSG Technician
- ☐ PSG Trainee

Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE

First Name	Middle Name	Last Name
Current Address (Street, City, State, Zip)		Telephone
New Address (Street, City, State, Zip) and Effective Date		Social Security No.
Place of Birth (City and State)		Date of Birth (Month, Date, Year)

Height (Ft., In.)	Weight	Hair	Eyes	Complexion	Scars, Marks	Sex: Male Female

NAME AND LOCATION OF SCHOOLS	FROM (Month, Day, Year)	TO (Month, Day, Year)
High School		
College/University		
Polysomnography Program		
Postgraduate Study		

BRPT Registry Number: _____

I HAVE APPLIED FOR LICENSURE, REGISTRATION OR PERMIT IN THE FOLLOWING STATES OR COUNTRIES	Year	GRANTED CURRENT				NUMBER	APPLICATION BASED UPON	
		Yes	No	Yes	No		Endorse.	Exam.

In chronological order account for <u>all periods of time</u> beginning with the month applicant last received training/education up to the present time, leaving no gap in time of more than one month (employed, unemployed, studying for the exam, military service, extended vacation, etc.) Attach additional pages if necessary.

FROM (Month, Day, Year)	TO (Month, Day, Year)	NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION	EMPLOYER

NOTE

Attach a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 3"x4" in size. **Sign the photo in ink across the lower portion of the front side.**

Proof photos, negatives, copies, and instant photos are not acceptable.

CERTIFICATION

IF THE ANSWERS TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

	Y	N	
1.	☐	☐	Have you ever failed a registration exam?
2.	☐	☐	Have you ever been refused a professional license/registration/permit?
3.	☐	☐	Have you ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations?
4.	☐	☐	Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct?
5.	☐	☐	Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration/permit?
6.	☐	☐	Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice polysomnography related respiratory care with reasonable skill and safety?
7.	☐	☐	Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action?
8.	☐	☐	Do you currently have or have you had problems with the use of alcohol, stimulants, habit forming and/or illegal drugs in the past five years which in any way impairs or limits your ability to practice polysomnography related respiratory care with reasonable skill and safety?

I, _____, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct; that I am the lawful holder of the degrees/credentials listed, and that such degrees/certificates were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board and information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practicing polysomnography related respiratory care.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information with this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my permit to practice polysomnography related respiratory care in the State of Idaho.

I further declare that the photo of myself attached hereto was taken on or about _____, 20 ____, my age being _____.

State _____ County of _____

Subscribed and Sworn to before me this ___ day of _____, 20___.

(SEAL) Notary Signature _____

My commission expires _____

_____

Signature of applicant

CERTIFICATE OF PROFESSIONAL EDUCATION

Please have the following completed by the appropriate educational institution and return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. #140, Boise, ID 83704.

Full Name of Applicant:	
Address:	
Social Security Number:	Date of Birth:
Associate Degree: Certificate of Completion:	Date of Degree: Date of Certification:

Dates of Attendance:	**From (Date)**	**To (Date)**
First Year		
Second Year		
Third Year		
Fourth Year		

I hereby certify that the above named applicant completed training as indicated above and received a certificate of completion.

Please type or print name of Director

Signature of Director

Name of School or Facility

(SEAL)

If changed, present name

City State Zip

Date of This Certification

Applicant's signature

VERIFICATION OF TRAINING

I am applying for a permit to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr., Ste. 140, Boise, ID 83704. (This form can be duplicated.)

Applicant's Name: _____

Address: _____

EMPLOYMENT

Employer (facility): _____

Address: _____

_____

Supervisor (Full Name) Telephone License No.

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TRAINING

Date: _____ TO _____ No. of Hours _____

Duties during the above dates: _____

_____

_____

_____

_____

_____

Proficiency in above duties (circle one): Poor Fair Good Excellent

AFFIDAVIT OF SUPERVISOR

I have carefully read the above questions regarding training and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct.

_____

Signature of Supervisor

State _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary signature _____

My commission expires _____

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return for directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704. (Note: **Two (2)** certificates of recommendation are required. Please duplicate this form. Recommendations should be from persons who have known the applicant for at least **one (1) year**.

Applicant's Name: _____

Address: _____

_____

Do you request that this information be confidential? ___Yes ___No

TO: Idaho State Board of Medicine:

I have known _____ for _____ years,

from _____ to _____. To the best of my knowledge

he/she is of good moral and professional character and ethics.

Additional Comments:

Signature _____

Printed Name _____

Date _____

Address _____

_____

Profession _____

SUPERVISOR AFFIDAVIT

I am applying for a permit to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr., Ste. 140, Boise, ID 83704.

Applicant's Name: _____

Address: _____

_____

FACILITY
Must provide a Supervisor Affidavit to the Board for each facility employed to practice polysomnography related respiratory care.

Name of Facility: _____

Address: _____
(Street) (Telephone)

_____
(City) (State) (Zip Code)

SUPERVISOR
Must be a polysomnography technologist/technician with an active Idaho permit, permanent licensed respiratory care practitioner, and/or physician and must complete the Supervisor Affidavit.

Name: _____
(Last) (First) (Initial)

Address: _____
(Street) (Telephone)

_____
(City) (State) (Zip Code) (Idaho License/Permit)

AFFIDAVIT OF SUPERVISOR
Applicant will work under my personal supervision and I assume responsibility for the applicant's work.

_____
Signature of Supervisor

State _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary signature _____

My commission expires _____